ABSTRACT

Objectives:

To investigate the causes of unintended pregnancies and in particular, reasons for non-use of contraception among young women attending a day unit for surgical abortion.

Methods:

Women between the ages of 16 and 20 attending a day unit at a hospital in the north of England who were due to have, or had recently had, a surgical abortion were interviewed about their knowledge of and views on contraception, sex education, and sexual health services. Twenty-four young women were interviewed, 22 on the day unit, one in her home and one over the phone, after the abortion. Interviews were recorded with the consent of the interviewees and fully transcribed. Transcripts were analysed using a grounded theory approach.

Results:

The most common reasons for non-use of contraception related to forgetting or "not thinking", being "in the moment" (i.e.,being "in the mood", not wishing to "break a spell"), the influence of alcohol, and pressure from young men not to use condoms. Lack of knowledge was rarely cited as a reason.

Conclusions:

Young people are aware of the need to use contraception, and knowledgeable about its availability; however, they often do not think about using it, especially where sex is unplanned. Alcohol and being "in the moment" are key factors which diminish the likelihood of contraceptive use.

INTRODUCTION

Reducing teenage pregnancy and lowering rates of young parenthood are key UK government priorities. Since the launch of the Teenage Pregnancy Strategy[1] and the establishment of the Teenage Pregnancy Unit, a cross-government unit set up in 1999 to manage the Strategy in England, a desire for a reduction in under 18 pregnancies continues to drive policy[2,3]. At present, in the UK both under 16 and under 18 pregnancy rates are at their lowest level since the 1980s, although some Local Authorities saw pregnancy and abortion rates rise over the latter part of 2008. However, the UK still has the highest rate of teenage pregnancy in Western Europe, and within the country several "hotspots" exist, of which the Yorkshire city of Kingston upon Hull is one. Data published by the Office for National Statistics[4] show that in 2007 compared to a pregnancy rate of 41.7/1000 nationally, the rate amongst under 18s resident in Hull was 70.4 pregnancies/1000. Of these, 37% led to abortion. The target is to reduce under -18 pregnancies by 55% from the 1998 baseline of 84.6 /1000, to 38.1/1000 in 2010. By 2007 the reduction from the 1998 baseline was 17%. Quarterly under 18 pregnancy data for the 3rd quarter of 2008 shows that the rate for Kingston upon Hull was 68.6/1000.

The city of Kingston upon Hull, in the north of England, has high levels of deprivation and social disadvantage, as well as high levels of teenage pregnancy and young motherhood. Data produced by Hull City Council[5] indicate that it is the 9th most deprived local authority district out of 354 in England, and that almost half of the people in Hull live in electoral wards that are amongst the 105 most deprived wards in the UK. Educational attainment is relatively poor, with fewer than half of pupils at age 16 achieving the accepted national standard for school-leaving examinations and in 2003/04, 18.4% of year 11 pupils at age 16 not going into education, employment or training compared to 13.5% nationally. At the April 2001 census, Hull appeared to have 17.1% of its young people aged 16 to 18 not in employment or full-time education. This was the highest for any English local authority and considerably above the national average of 9.6%. Therefore the high rates of pregnancy and parenthood at a young age should be seen within a context of living in an area with low rates of education after the age of 16 and high rates of youth unemployment, when there is well-documented

evidence that unintended pregnancies amongst adolescents are closely linked to lower socio-economic status[1].

Much work has been undertaken internationally (e.g., in the UK, elsewhere in Europe, the USA, and Australia) on reducing the incidence of teenage pregnancies, and much of it has focussed on sex education in schools[6-11], access to contraception and use of sexual health services[12-16]. Buston and Wight[6] suggest that young women felt that school sex education was often too biological in approach, and should be taught earlier, particularly for those teenagers who may commence sexual activity early. For many young people, sex education lessons can be uncomfortable, leading to disruptive behaviour and a lack of willingness to participate in the lesson[7,8]. Many feel that school sex education could be improved[9] and younger teenagers in particular would like more wide-ranging lessons that focus not just on biology but on emotions and relationships[10]. At the same time, teachers feel that they are constrained by pressure of time and lack of training, as well as in some cases lack of enthusiasm and confidence[11]. Dei et al.[13] suggest that lack of contraceptive use by young Italian women is not due to lack of knowledge but to lack of ability to apply that knowledge, especially in situations where "irrational desire" takes over. In other settings, knowledge may be widespread but other factors, particularly alcohol, may influence the successful use of contraception[14,15]. In particular, self efficacy amongst girls is an important indicator of the likelihood of successful use of contraception[16].

Health practitioners are often perceived by teenagers as being unsympathetic and overly critical[17], and access to services that are designed for teenagers and take into account their particular needs and fears, especially around confidentiality and visibility, is felt to be crucial[18]. Research on attitudes to contraception has tended to focus on girls and young women. Where research has been conducted amongst youths of both genders, it suggests that boys have some of the same concerns as girls such as visibility in accessing services and the need for confidentiality[17,18], but also that boys have different approaches to responsibility for

contraception[16,19,20] . Other research[21,22] highlights the difficulties for both genders in negotiating condom use, and for young women in particular, the successful negotiation of safe sex is less likely when confounded by notions of romantic love[23].

This study aimed to investigate why young women who were having an abortion in the city of Kingston upon Hull had become pregnant, and to consider factors such as:

- knowledge about sex and contraception;
- access to sexual health services;
- attitudes to use of contraception;

with a view to ascertaining the role each of these factors might have played in the resulting unintended pregnancy. We wished to identify the circumstances under which these young women, who clearly did not want to continue with the pregnancy, had conceived. Young women who wanted to be pregnant, and intended continuing with the pregnancy whether or not that pregnancy was planned, were not included in the study.

METHODS

This qualitative interview study was carried out between February and July 2007. In depth interviews were undertaken with 24 women aged between 16 and 20 who were attending a Gynaecological Day Unit (GDU) for surgical abortion. Two interviews were carried out after the abortion, one in the respondent's home, and one over the telephone. A semi-structured interview schedule was used, covering the key topics of knowledge of, access to and use of contraception. The schedule was devised by the authors in collaboration with the Teenage Pregnancy Unit of Hull City Council. Each interview began by asking the participant what she remembered about sex education at school, and who she talked to or where she went if she wanted advice and information about sexual health and contraception. A series of prompts were used to ensure that the interview covered the three key topics, but issues raised by the interviewees were allowed to direct the interview to areas that were of most significance to them.

This was a pragmatic study, utilising recruitment by purposeful sampling, whereby the site of the study, and the individuals to be studied, were selected in order to "purposefully inform an understanding of the research problem and central phenomenon in the study" (p. 125)[24]. Recruitment continued until saturation was reached and no new topics were emerging in the interviews. This process was managed by the consultant who identified respondents on the day of admission for surgery, invited them to be interviewed, introduced them to the researcher and gave them an information sheet to read about the study. Exclusion criteria were refusal to take part, and emotional vulnerability. This was based on clinical assessment by the consultant, of the possibility of being caused anxiety or distress if interviewed. After having been given the time to read and digest the written information, the young women were asked by their named nurse (i.e. the nurse who was responsible for their care whilst on the ward), f they had any questions and were still willing to be interviewed. The researcher and the consultant were not present during this conversation. Of the 29 young women initially approached, two changed their minds at this point; two who had previously consented had fallen asleep, and one felt unwell so was not interviewed. Apart from the one interview carried out in the interviewee's home and the one telephone interview, all other interviews took place in a private consulting room off the ward, and lasted between 9 and 25 minutes.

All interviews were conducted by the first author and were recorded with the consent of the interviewee. They were later fully transcribed, and analysed in accordance with principles of grounded theory. Using a grounded theory approach to analysis[25,26], the process of developing broad categories began once the first two interviews had taken place. These were built up and refined as further interviews and analyses took place, using a constant comparative approach[27] to search for, and then explain, deviant cases. As the initial analysis of transcripts took place whilst the interview process was ongoing, with preliminary analysis enabling a refinement of questions and the pursuit of emerging avenues of enquiry, it allowed "emerging theoretical categories to shape the data collection" (p. 1162)[28]. All the transcripts were then examined

again once all the interviews had been completed to ensure that categories were dense and rich, and that the coding reflected "as many of the nuances of the data as possible." (p. 114)[29]. Thus, rather than simply counting occurrences or listing themes which emerged from the data, the iterative nature of the analytical process enabled the development of an account which is grounded in the data provided by the interviewees. The strengths of grounded theory lie in this ability to pick up on issues and ideas emerging from the data, not being restricted to preconceived ideas about the data or about the lives and concerns of the interviewees.

The study had ethical approval from the local research ethics committee.

RESULTS

Within the broad category of "not using contraception", the most common reasons were forgetting, not thinking, being "in the moment", the influence of alcohol, and the influence of young men. This took the form of either their objections to using a condom or refusal to use one, or the subtle pressure not to stop because a condom would interrupt "the moment". This paper presents detailed findings concerning non use of contraception, and considers the reasons for non-use.

Quotations from the interviews are labelled "Respondent number/age of respondent", so "R15/19" is Respondent 15, aged 19.

Several respondents were on the pill, but had forgotten to take it, or had taken it irregularly. Most respondents said that not only had they forgotten to take their pill, but said that they knew their friends forgot too:

> *Forgetting is a problem, it's if you're busy, or you rush out, and you forget to take it, and it's like, 'oh God, I forgot to take it'. I've done it a few times where I've forgot and thought 'oh damn'.* (R15/19)

Two respondents said they knew friends who had forgotten to take the pill for several days, and had then taken a number of pills at the same time to "catch up" – in one case, seven pills on one occasion. Two respondents were on the pill, had taken it regularly, but had had stomach upsets including vomiting and were unaware that this could diminish their level of protection.

Those respondents who had not used contraception at all had a variety of reasons. Some respondents had had bad experiences with certain types of contraception, and had been "caught out" in the change from one method to another.

> *When I got it* (the contraceptive implant) taken *out I went away the next day. And that's when I got pregnant, when I was away for two weeks. So, yeah* (laughs) *if I hadn't gone away I don't think I would've got pregnant.* (R3/17)

Others simply had not used it:

> *Nothing. Yeah, I know, I'm stupid. I should've known.* (R23/18)

The reasons for this are varied and deserve further detailed exploration, as an understanding of failure to use contraception is a major concern in terms of reducing unwanted pregnancies. For some young women, it was a case of thinking "it won't happen to me":

> *I just thought I won't get pregnant, but I did.* (R6/16)

Several respondents felt this was quite a common attitude amongst people they knew:

I don't think they think they'll get caught pregnant real quick, or anything, like that. They just don't bother using anything. And then when they do, it's like, oh God. (R15/19)

It was suggested that young women did not realise how easy it was to become pregnant, and if they knew, they would take precautions. However, being rational about contraception is unlikely when in "the moment" and irrational desire takes over:

Because *it's too much, err, time consuming, really, if you like want to do it straight away you don't think about a condom, can't you tell?* (laughs) *You just go for it, so you forget about them really, and then it's afterwards, you regret it and think oh God why didn't I use one?* (R10/17)

They just get caught in the moment and they daren't say "Have you got a condom?" You just go on with it and think "Oh, it'll be alright," then it's not. (R19/18)

Not stopping to think about using condoms is compounded by a number of factors, including embarrassment about discussing them, and having the confidence to ask a partner if he has a condom or will use one:

I mean, cos I know them saying, like, "No, I aren't using one", then you should say no, obviously, shouldn't you, but not a lot of girls do. I mean, I've done it myself, so I can imagine other teenagers doing it. So, I think most of it's the confidence that you need. I think they feel a bit stupid saying no, you know. (laughs) (R16/18)

Yeah, yeah, yeah definitely, because like, sometimes, like during sex they don't speak, so the girl is, like, scared to say "Have you got a condom?", and the boy, well, the

boy will just like get on with it won't he, really? He'll just think, "Forget about it, oh it doesn't matter". (R19/18)

Almost all the respondents said that young men did not want to use condoms, and tried to persuade their partner to have sex without one, because it would be better, or because stopping to put on a condom would spoil "the moment":

I think most of it you feel stupid, you know, but erm, a couple of times I was saying "Shall we use a condom?", cos obviously I don't want to be getting pregnant, like in the situation I'm in now. And they're just like basically, no. You know. No. No. It's crap, it's crap. So I think a lot of it is if you're confident to ask the person to use one, and confident to say no, then you're alright. But I think a lot of it can be the, erm, boyfriends as well, or whoever you're sleeping with. (R16/18)

Some of them whinge that it takes away the feeling, the sensation, things like that. (R22/18)

Alcohol appears to be a major influence on behaviour which leads to unprotected sex, with people not stopping to think, or to discuss contraception:

Yeah that's how I got pregnant with my first one. I got drunk, cos - it was my birthday, and my birthday was on a school night, so we went out on the weekend. That's when I got pregnant with him. Yeah, that's why. (R3/17)

I know it sounds silly but at the time you aren't bothered, when you're drunk. Well you are, but you just seem to think you haven't got a condom, it doesn't matter this time round, I'll be alright. (R16/18)

Alcohol means people are less inhibited, and more likely to take risks:

> *Yeah, cos it gives people more confidence,… oh, it makes people more reckless. And if they were unsure about doing something, once they've been drinking they think, oh it'll be alright now.* (R5/20)

> *Drinking and just forgetting about it, people go out on town and drink and forget about it, they lose inhibitions.* (R21/18)

Parties or other occasions where young people are consuming alcohol were also settings for young men to avoid using condoms, not so much in terms of putting pressure on young women, but of taking advantage of situations where decision-making was impaired:

> *I don't think they put pressure on not to use them, they just don't. That's what they're like. They don't use them. Cos boys I think do take advantage of girls. Like say if they're at a party and they're drunk, that's when they'll take advantage.* (R14/18)

> *I mean, a lot of my friends, used to always go out on a Friday night, I mean even if it was like at a friends' house, they'd end up getting drunk and end up sleeping with someone.* (R19/18)

This issue was perceived as one which was becoming increasingly problematic as more people drank, at a younger age:

> *There's more younger people drinking now than there was when I was like 14... and I think that's why more people are getting pregnant, because they're drunk, and they*

don't want to like talk about anything, they just go ahead and do it because they don't know what they're doing. (R3/17)

There was also a perception that club nights aimed at young people, especially "Under 18s Nights" were an occasion for opportunistic sex or one night stands, whether or not alcohol was involved:

They do have sex behind [arena], or behind [nightclub], at under 18s, or in the toilets. It's disgraceful. (R10/17)

Most respondents gave more than one reason for non-use of contraception, but the most common reason was not thinking / forgetting. The next most common reason was the influence of alcohol, followed by being caught "in the moment" and embarrassment, and young men's attitudes. Lack of knowledge was given as a reason by two respondents and cost of condoms by only one.

DISCUSSION

It appears from these interviews that lack of knowledge about sex and contraception, and access to sexual health services, did not play a major role in unintended pregnancies among these young women. Much more significant were the decision making processes around choosing (or not) to use contraception. As with Coleman and Ingham's work [30], this study suggests that young people do not use contraception consistently, and do not always think about it until after they become sexually active. Sex was often unplanned, and this lack of planning lessened the likelihood of contraception being used, especially where alcohol was involved. This study shows that a combination of factors – alcohol lessening inhibitions, being "in the moment", and being too embarrassed to discuss condom use – was likely to result in unprotected sex despite young people being knowledgeable about contraception and aware of how to access it.

Stone and Ingham[31] found that a very important determinant of contraceptive use was communication, or lack thereof, with a partner. A key finding of this study is that lack of communication plays a major role, with few respondents feeling comfortable about discussing condom use in particular. This was compounded by what was perceived to be young men's reluctance to use condoms, and assumptions about responsibility for contraceptive use. The evidence suggests that those in short term relationships or engaging in one night stands were much less likely to use contraception because sex was unplanned[12], but in a long term relationship where sex was planned, were likely to have discussed it with their partner.

Parkes et al.[32] argue that "encouraging teenagers to access services earlier may be achieved through improving knowledge about sexual health and service provision, since these were associated with service use". However, our study suggests that the "gap" as it were, has less to do with knowledge about services and sexual health, i.e. about risks of pregnancy from unprotected sex, and more to do with having the skills and ability to negotiate consistent use of contraception. In addition, risks of STIs and unprotected sex were rarely mentioned, meaning that for young people in this setting, the undesirable consequence of unprotected sex was often only seen in terms of an unplanned pregnancy. Buston, Williamson and Hart argue[33] that targeting teenagers of both sexes to promote the use of contraception, and to deliver the necessary skills for correct use of contraception, may reduce pregnancies. This certainly seems to be applicable in the setting of this study, particularly with regard to promoting the use of contraception to young men

The findings of this study suggest that despite access to a range of contraception being relatively easy in theory, use of it depends more on the circumstances surrounding the sexual encounter. This is particularly the case when sex is unplanned or a "one night stand". Better advice about correct use of the pill and consistent use of contraception of any sort, is clearly needed. The issues raised emphasise the benefits of long acting reversible methods of

contraception which are generally not user-dependent. This would still leave these young women vulnerable to sexually transmitted infections (STIs) but would at least prevent pregnancy. However, it would seem that the circumstances around the sexual encounter are key in terms of unintended pregnancies, with alcohol, unplanned sex, and male attitudes all playing a major role in non use.

There are some limitations to this study. As a focussed qualitative study taking place in a specific location, it was not designed to be representative, nor are the findings necessarily replicable to other settings. As the study only looked at reasons for unintended pregnancies amongst young women having an abortion, the young women interviewed may not have been typical of the wider population. There may also be an element of "post hoc rationalisation" in terms of explanations about why a young woman became pregnant, and she may not wish to appear to be "to blame". Nevertheless, the findings are consistent with other research in this field, which suggests that despite Kingston upon Hull having a high teenage pregnancy rate in comparison to other parts of the UK, young women in the city are not very different from other young British women when it comes to attitudes to use of contraception. This raises the question of whether the high rate of young motherhood in areas of social deprivation such as Hull has less to do with use of contraception and choosing to get pregnant, and more to do with the choice to keep an unintended pregnancy. In the light of media "scares" about teenagers choosing to get pregnant in order to gain housing and benefits, this deserves further exploration.

The study raises questions which need further investigation. As only young women were interviewed, yet they talked about young men's attitudes at length, more research should explore young men's views on contraception, STI transmission, risk and responsibility, and consider how much the views of young women about what young men think are actually reflected by those men. In addition, the interviews focussed on pregnancy and abortion as

consequences of unprotected sex; further studies amongst this population concerning behaviour and awareness of STIs would be worthwhile.

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